Gulfview Heights Primary School OSHC

39 Kiekebusch Road Gulfview Heights SA 5096 Tel: 08 8182 6950

Working together to reach new Heights

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Enrolment Form

CHILD DETAILS	CASUAL/PERI	MANENT			
FAMILY NAME	FIRST NAME:				
PREFERRED NAME:	GENDER: N	MALE/FEMALE			
DATE OF BIRTH:/	CRN:				
RESIDENTIAL ADDRESS:					
TOWN/SUBURB:		POSTCODE:			
PRIMARY LANGUAGE SPOKEN	AT HOME:				
DOES THE STUDENT IDENTIFY A	AS BEING OF ABORIGINAL <u>OR</u> TO	DRRES STRAIT ISLANDER DESCENT?			
No	Yes, Aboriginal Descent	Yes, Torres Strait Islander Descent			
IS THE CHILD IN STATE CARE? 1	No Yes				
Enrolling Parent/Guardian Info	rmation (Account Holder)				
Name:	Relationship to ch	nild: D.O.B:			
Address:		Postcode:			
Home Phone:	Mobile Phone:	Work:			
Place of employment:					
Email:	c	RN:			
Parent/Guardian Details					
Name:	Relationship to ch	nild: D.O.B:			
Address:		Postcode:			
Home Phone:	Mobile Phone:	Work:			
Place of employment:					
Email:					

Custody Issues/Court Orders (if applicable)

If parents are separated or divorced: Does the child have contact with both parents? Yes/No Is anyone legally denied access to the child? Yes/No

If there are court orders in place or any legal documentation relating to the custody of the children please provide a copy of this information with your enrolment.

Emergency Contacts (if parents are un-contactable and must be over 18 years of age)

		, ,
Contact 1		
Name:	Relationship	to Child:
Address:		Postcode:
Home Phone:	Work Phone:	Mobile Phone:

Contact 2			
Name:		Relationship to	Child:
Address:			Postcode:
Home Phone:	Work Phone:		Mobile Phone:

NOTE: It is very important you tell these people that you have nominated them. In nominating them, you give them authority to act on your child's behalf if neither parent/guardian can be located to pick up the child in an emergency and care for the child until he/she can be returned home.

Other adults authorised to collect child:				
1	Name:	Mobile:	Relationship to child:	
2	Name:	Mobile:	Relationship to child:	

NOTE: The people nominated here have been given approval only to collect the child and should NOT be contacted in case of an emergency.

Medical Information

Child's Name:		Туре	Please Provide:
Allergies: if your child is required			An Action Plan
to take medication in the case of	Yes		A Risk Management Plan
an allergic reaction, please			Medical Conditions
complete a Medical Management	No		Communication Plan
Plan (Additional forms required)			
			An Action Plan
Disabilities: Does your child have	Yes		 A Risk Management Plan
physical limitations or a medical	No		 Medical Conditions
condition. Please provide details			Communication Plan
			An Action Plan
Emotional/Behavioural Problems	Yes		A Risk Management Plan
	No		Medical Conditions
			Communication Plan
Special Diet	Yes		An Action Plan
	No		A Risk Management Plan
			Medical Conditions
			Communication Plan
Asthma and use of puffers – if			
your child is required to take	Yes		An Action Plan
medication in the case if an	No		A Risk Management Plan
asthma attack, please complete			

an Asthma Risk Management		Medical Conditions	
Plan. (Additional forms required)		Communication Plan	1
Medications – if your child is		An Action Plan	
required to take medication at		A Risk Management	Plan
OSHC a Medical Management	Yes	Medical Conditions	
Plan is required before the	No	Communication Plan	1
enrolment can be processed. (Add	ditional		
forms required			
please see Director)			
		An Action Plan	
Other Medical	Yes	A Risk Management	Plan
	No	Medical Conditions	
		Communication Plan	1
Cultural/Religious Requirements	Yes		
	No		
Immunisations up to date (includi	ng COVID		
vaccinations)?		A copy of immunisate	tion records
(Please supply a copy of	Yes		
Immunisation records)	No		
NOTE: Please supply the service wit	th required	medications in original containers with the child's name	e clearly
• • •	•	inister medication form where necessary.	•
		,	
Medicare Number:		_ Health Care Card Number:	
Private Health/Medical Renefits Co	wer with:	Ambulance Cover? Yes/No	
Trivate ficating Wicaldar Belieffes co		Ambalance cover. Tesyno	
We aim to provide inclusive quality	care for a	range of children from differing cultures and backgroun	ıds. Please
share with us a little of your family	's backgrou	ind information so we can incorporate this within our p	rogram.
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Parent/Guardian Declaration

I understand that:

- I agree to pay the required fee for my child's booked OSHC/Vacation Care hours and accept the policies and rules of the service.
- Each child must be signed in and out each day on the Attendance Record.

If an illness or accident occurs, the parent/guardian will be contacted as soon as possible. However, in the event of my child requiring urgent medical treatment, I authorise the care providers and staff

 To obtain appropriate medical assistance and I agree to pay all medical and transport costs incurred on behalf of my child.

We endeavour to keep Gulfview Heights Primary School OSHC/Vacation Care a happy and safe environment for children. To do so we ask that children in our care adheres to our behavioural rules. Children who frequently exhibit unacceptable behaviour may be excluded from the program.

- The supervision and care of children is strictly limited to the hours care is provided. See handbook for operating hours.
- The OSHC/Vacation Care service must be notified if my child/ren are to be collected by someone that is not nominated on this form.
- Cancellation or changes to permanent/casual bookings require 24 hours' notice to be given.
- The OSHC/Vacation Care Service will refuse a child/ren access to the service if they have an outstanding account longer than 28 days.
- I will undertake to notify the service of any changes to details on this form.

I certify that all the information given on this form is true, accurate and correct. I further certify that I have read and agree to adhere to the policies and rules regarding Gulfview Heights Primary School OSHC/Vacation Care Service.

Print Name:
Signature:
Date:

Consents

	Please
	initial box
I consent for my child to take part	
in supervised walking excursions	
and visiting the local playground	
as part of the services After	
School Care program.	
I consent to my child to be	
photographed as part of the Out	
of School Hours Care program	
and to have them displayed	
around the service.	
I consent for OSHC staff to apply	
sunblock to my child if they	
require assistance.	
I consent for my child to watch	
PG-rated movies/videos/DVDs at	
the discretion of the Director.	
I consent for OSHC staff to ring	
for an ambulance for my child in	
the event of a medical emergency	
and parents/guardians will be	
contacted immediately.	
I consent for OSHC staff to	
administer simple first aid to my	
child if the need arises.	

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Booking Form

Please indicate your required OSHC bookings on the table below

Before School Care	Monday	Tuesday	Wednesday	Thursday	Friday	
6.30am – 8.35am						
From//	Until/	//	Ongoing permanent bookings Yes/No			

After School Care	Monday	Tuesday	Wednesday	Thursday	Friday	
3.10pm – 6.30pm						
From//	Until /	'/	Ongoing permanent bookings Yes/No			

I have no regular times at this stage – I would like to use the service on a casual basis.	
What date will your child commence?	

Parent/Guardian

I agree to the terms and conditions of the above. Please sign below
Print name:
Signature:
Date:

Office Use Only

Office Use Only	
1. CRN	
2. D.O.B	
3. Bookings	
4. Email address	
5. OSHC Medical	
Plans received	
6. Hat	
7. Folder	
8. Birthday Chart	
9. Programming	
Entered by:	
Date:	